

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/22/2015
NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLIAMS FERRY RD LENOIR CITY, TN 37771		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments A licensure survey and complaint investigation #36551, #36666, #36665, #36032, #36549, #36218, #36725, #36727, #36728, #36866, and #36867, were completed on July 20-22, 2015, at Baptist Health Care Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DATE FORM

6899

YP6Y11

If continuation sheet 1 of 1

Melvin A. Franklin

Administrator

8/13/15